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104TH CONGRESS
2D SESSION

S. 1600

To establish limitations on health plans with respect to genetic information, and for other purposes.

IN THE SENATE OF THE UNITED STATES

MARCH 7 (legislative day, MARCH 6), 1996

Mrs. FEINSTEIN (for herself and Mr. MACK) introduced the following bill; which was read twice and referred to the Committee on Labor and Human Resources

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A BILL

To establish limitations on health plans with respect to genetic information, and for other purposes.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE.

This Act may be cited as the "Genetic Fairness Act of 1996".

SEC. 2. DEFINITIONS.

As used in this Act:

(1) FAMILY MEMBER.—The term "family member" means, with respect to an individual, another

individual related by blood to that individual or a spouse or adopted child of the individual.

(2) GENETIC INFORMATION.—The term "genetic information" means the information about genes, gene products or inherited characteristics that may be derived from an individual or a family member.

(3) GENETIC SERVICES.—The term "genetic services" means health services provided to obtain, assess, and interpret genetic information for diagnostic and therapeutic purposes, and for genetic education and counseling.

(4) GENETIC TEST.—The term "genetic test" means a procedure that is generally accepted in the scientific and medical communities and that is performed for the purposes of identifying the presence, absence, or alternation of any gene or chromosome.

(5) HEALTH PLAN.—The term "health plan" means—

(A) a group health plan (as such term is defined in section 607 of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1167)), and a multiple employer welfare arrangement (as defined in section 3(40) of such Act) that provides health insurance coverage; or

(B) any contractual arrangement for the provision of a payment for health care, including any health insurance arrangement or any arrangement consisting of a hospital or medical expense incurred policy or certificate, hospital or medical service plan contract, or health maintenance organization subscriber contract.

(6) INSURER.—The term "insurer" means—

(A) an insurance company, health care service contractor, fraternal benefit organization, insurance agent, third party administrator, insurance support organization or other person subject to regulation under State health insurance laws;

(B) a managed care organization; or

(C) an employee welfare benefit plan regulated under the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1001 et seq.).

(7) SECRETARY.—The term "Secretary" means the Secretary of Health and Human Services.

SEC. 3. PROHIBITIONS.

(a) GENETIC INFORMATION.—An insurer offering a health plan may not—

(1) terminate, restrict, limit, or otherwise apply conditions to coverage of an individual or family

member under the plan, or restrict the sale of the plan to an individual or family member;

(2) cancel or refuse to renew the coverage of an individual or family member under the plan;

(3) deny coverage or exclude an individual or family member from coverage under the plan;

(4) impose a rider that excludes coverage for certain benefits and services under the plan;

(5) establish differentials in premium rates or cost sharing for coverage under the plan; or

(6) otherwise discriminate against an individual or family member in the provision of health care;

on the basis of any genetic information concerning an individual or family member or on the basis of an individual's or family member's request for or receipt of genetic services.

(b) GENETIC TESTS.—An insurer offering a health plan may not require an applicant for coverage under the plan, or an individual or family member who is presently covered under the plan, to be the subject of a genetic test or to be subjected to questions relating to genetic information.

(c) NOTICE OF RIGHTS.—An insurer offering a health plan shall, in the enrollment information provided by the insurer concerning such plan, provide an enrollee

with a written statement disclosing the rights of the enrollee under this Act. Such statement shall be in a form and manner that is noticeable to and understandable by an average enrollee.

(d) ENFORCEMENT.—

(1) PLANS OTHER THAN EMPLOYEE WELFARE BENEFIT PLANS.—The requirements established under subsections (a), (b), and (c) shall be enforced by the State insurance commissioner for the State involved or the official or officials designated by the State, except that in no case shall a State enforce such requirements as they relate to employee welfare benefit plans.

(2) EMPLOYEE WELFARE BENEFIT PLANS.—With respect to employee welfare benefit plans, the Secretary shall enforce the requirements established under subsections (a), (b), and (c) in the same manner as provided for under sections 502, 504, 506, and 510 of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1132, 1134, 1136, and 1140).

(3) PRIVATE RIGHT OF ACTION.—A person may, after that person has exhausted all available administrative remedies, bring a civil action—

(A) to enjoin any act or practice which violates subsection (a), (b), or (c);

(B) to obtain other appropriate equitable relief—

(i) to redress such violations; or

(ii) to require the Secretary of Health and Human Services to enforce any such subsections, or

(C) to obtain other legal relief, including monetary damages.

(4) JURISDICTION.—State courts of competent jurisdiction and district courts of the United States have concurrent jurisdiction of actions under this subsection. The district courts of the United States shall have jurisdiction, without respect to the amount in controversy or the citizenship of the parties, to grant the relief provided for in paragraph (3) in any action.

(5) VENUE.—For purposes of this subsection the venue provisions of section 1391 of title 28, United States Code, shall apply.

(6) REGULATIONS.—The Secretary may promulgate such regulations as may be necessary or appropriate to carry out this section.

SEC. 4. EFFECTIVE DATE.

This Act shall apply to any health plan offered or renewed on or after the end of the 90-day period beginning on the date of the enactment of this Act.

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